STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING _____ B. WING _____	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGOLAND CHRISTIAN VILLAGE	6685 E 117TH AVE CROWN POINT, IN 46307

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R 000	INITIAL COMMENTS The following State Residential findings are in accordance with 410 IAC 16.2-5.	R 000		
R 036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights-Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to notify a resident's physician related to a weight loss for 1 of 7 residents reviewed for weight loss in a sample of 7. (Resident #165) Findings include: Resident #165's record was reviewed on 02/18/11 at 9:45 a.m. The resident's diagnosis included, but was not limited to, hypertension. The resident's weight record, dated 04/10, indicated the resident's weight was 137 pounds. The weight record indicated the resident's weight on 01/04/11 was 123 pounds. This was a 10.2% weight loss in nine months. During an interview on 02/21/11 at 9:40 a.m., the Wellness Care Coordinator indicated when the weight loss had been brought to her attention on 02/18/11, she notified the resident's physician.	R 036		

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R 036	Continued From page 1 A Physician's Concern Report, dated 02/19/11, indicated the following new orders, "1. weekly weights 2. CBC (complete blood count) with differential, Basic Metabolic Panel (electrolytes), T3, T4, TSH (thyroid tests), total protein, albumin, pre albumin. 3. Ensure (dietary supplement) bid (twice a day)."	R 036		
R 217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.	R 217		

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R 217	Continued From page 2 This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure services offered to the resident were documented on the resident's service plan related to medication management and mobility for 2 of 7 residents reviewed for service plans in a sample of 7. (Residents #158 and #178) Findings include: 1. Resident #159's record was reviewed on 02/21/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, muscle weakness and osteoarthritis. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week. The Self-Administration of Medications Assessment, dated 11/12/10, indicated the resident could safely self administer her medications. The resident's,Service Plan Assessment, dated 11/12/10, indicated the resident required maximum supervision for medication management administration. The form indicated, "maximum supervision-Assistance Management for compliance, irregular regimen, facility intervention, oversight or direct management or medication distribution...Needs order of supplies, coordination of securing medication and routine instruction of usage." The area on the comments section, which the Wellness Care Coordinator indicated was the resident's service plan, was left blank. The, Service Plan Assessment, dated 11/12/10,	R 217		

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R 217	Continued From page 3 indicated the resident required assistance for ambulation, mobility and transfers. The area on the comments section was left blank. During an interview on 02/21/11 at 8:40 a.m., the Wellness Care Coordinator indicated there were no comments written on the service plan. 2. Resident #178's record was reviewed on 02/21/11 at 8:45 a.m. The resident's diagnoses included, but were not limited to, hypothyroidism and legally blind. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week. The Self-Administration of Medications Assessment, dated 09/23/10, indicated the resident could safely self administer her medications. The resident's MAR dated 02/11, indicated the staff at the facility were setting up the resident's medication for a week at a time and the resident was self administering the medication after they were set up. The resident's Service Plan Assessment, dated 09/26/10, indicated the resident required assistance with ambulation, mobility and transfers. The comments section indicated, "Uses a walker. Has had recent fall. Unable to locate 3rd floor per self if an emergency. The comments lacked documentation to indicate what service would be provided by the facility and who would provide the service. The, 09/26/10 Service Plan Assessment	R 217		

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R 217	Continued From page 4 indicated the resident required assistance with medication management and administration. The comments section indicated, "Meds given per staff. Uses (pharmacy name). Meds need to be called in. The comments section lacked documentation the resident was self administering medication. During an interview on 02/21/11 at 8:55 a.m., the Wellness Care Coordinator indicated there was no service plan for medication management.	R 217		
R 244	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted. This RULE is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure not more than 1 scheduled medication administration was prepared related to the facility setting up medications for a week for 3 of 4 residents who self administer medications in a sample of 7. (Residents #159 #178, and #184) Findings include: During an observation on 02/18/11 at 9:05 a.m., Resident #178 was in her apartment sitting in her recliner. The resident indicated, during the observation, she self administers her own medications after the staff set up her medications for the week. During an observation on 02/18/11 at 9:20 a.m., resident #184 was sitting in her room. There was a plastic medication container marked with the days of the week on the resident's counter in her	R 244		

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R 244	Continued From page 5 kitchen with loose medication stored in the plastic container. During an observation on 02/18/11 at 9:25 a.m., resident #159 was sitting in her wheelchair in her room. The resident indicated, during the observation, that she takes her own medications after the facility sets up her medications for the week. 1. Resident #184's record was reviewed on 02/21/11 at 8:10 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and pulmonary hypertension. The resident's Physician's Recapitulation Orders, dated 02/11, indicated the resident could self-administer her own medications. The Self-Administration of Medications Assessment, dated 09/22/10, indicated there were no concerns with the resident doing the self administration of the medication. The resident's Medication Administration Record (MAR) dated 02/11, indicated the staff at the facility were setting up the resident's medication for a week at a time and the resident was self administering the medication after they were set up. 2. Resident #178's record was reviewed on 02/21/11 at 8:45 a.m. The resident's diagnoses included, but were not limited to, hypothyroidism and legally blind. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week.	R 244		

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R 244	Continued From page 6 The Self-Administration of Medications Assessment, dated 09/23/10, indicated the resident could safely self administer her medications. The resident's MAR, dated 02/11, indicated the staff at the facility were setting up the resident's medication for a week at a time and the resident was self administering the medication after they were set up. 3. Resident #159's record was reviewed on 02/21/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, muscle weakness and osteoarthritis. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week. The Self-Administration of Medications Assessment, dated 11/12/10, indicated the resident could safely self administer her medications. The resident's MAR, dated 02/11, indicated the staff at the facility were setting up the resident's medication for a week at a time and the resident was self administering the medication after they were set up. During an interview on 02/18/11 at 9:35 a.m., the Wellness Care Coordinator indicated a nurse from the facility sets up medication for six residents. She indicated they had been doing this since September.	R 244		

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R 356	Continued From page 7	R 356		
R 356	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure an emergency information file was immediately accessible for 1 of 5 residents reviewed for emergency files in a sample of 7. (Resident #183) Findings include: Resident #183's record was reviewed on 02/21/11 at 9 a.m. The resident's diagnoses included, but not limited to, hypertension and lumbar pain. The resident had been admitted into the facility on 01/15/11. There was a lack of documentation to indicate the resident had an emergency file available.	R 356		

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R 356	Continued From page 8 During an interview on 02/18/11, the Wellness Care Coordinator indicated the resident did not have an emergency file.	R 356		